



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20291

AUG 7 1997

TO: Heads of Operating Divisions  
Heads of Staff Divisions

FROM: The Secretary

SUBJECT: Department Policy on Consultation with American  
Indian/Alaska Native Tribes and Indian Organizations

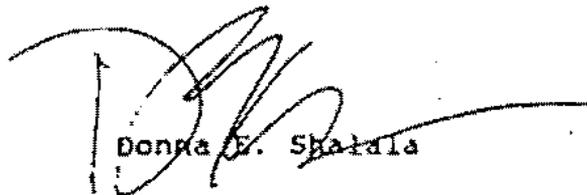
The President's Memorandum of April 29, 1994, titled, "Government-to-Government Relationship with Native American Tribal Governments" that was sent to the heads of executive departments and agencies reaffirmed the unique relationship between the U.S. Government and Native American Tribal Governments as stated in the Constitution, treaties, statutes and court decisions and directed each executive department and agency to consult with tribal governments prior to taking actions that affect them.

The Domestic Policy Council (DPC) Working Group on Indian Affairs, chaired by Secretary Babbitt, has requested that each Department develop its own operational definition of "consultation" with Indian tribes to meet the requirements of both the Indian Self-Determination and Educational Assistance Act, Public Law 93-638, and the President's Memorandum.

The DPC's recommendations led to the creation of an HHS Working Group on Consultations with American Indians and Alaska Natives. Co-chaired by Jo Ivey Boufford, M.D., former Acting Assistant Secretary for Health, and Michael H. Trujillo, M.D., Director, Indian Health Service, this group was comprised of representatives of the Department's major Operating Divisions and Office of the Secretary Staff Divisions [OPDIV/STAFFDIV]. During several meetings, the group explored the broad array of American Indian and Alaska Native (AI/AN) programs within the Department and developed a report recommending a Department-wide consultation plan (attached). I have accepted the Working Group's recommendations in the attached report and have designated the OS/Office of Intergovernmental Affairs (IGA) as the lead for the Department. As stated in the Working Group's report, each OPDIV/STAFFDIV should develop their own individualized consultation plan consistent with HHS policy. Completed plans should be submitted to IGA by August 29. Each OPDIV/STAFFDIV should submit an annual progress report on consultations conducted during the previous fiscal year to IGA no later than December 31 of each year.

Page 2 - Heads of Operating Divisions  
Heads of Staff Divisions

I know all of you share with me a commitment to ensure that the intent and spirit of the President's Memorandum is fully embraced in the consultation process that we are implementing.



Donna E. Shalala

Attachment

TAB A: Working Group Report

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
WORKING GROUP REPORT ON CONSULTATION  
WITH  
AMERICAN INDIANS AND ALASKA NATIVES  
REPORT

SUMMARY AND RECOMMENDATIONS

I. INTRODUCTION

The Domestic Policy Council (DPC) Working Group on Indian Affairs chaired by Secretary Babbitt has requested that each department develop its own operational definition of "consultation" with Indian tribes to meet the requirements of both the Indian Self-Determination and Educational Assistance Act, Public Law (P.L.) 93-638, and the April 29, 1994, Executive Memorandum on Government-to-Government Relations with Native American Tribal Governments. Each department should also develop mechanisms to ensure that Native American tribal governments are given an opportunity to provide input on department plans and that the approach decided upon is clearly communicated to Indian communities.

The United States (U.S.) government and the governments of American Indians and Alaska Natives (AI/AN or Indian people) have a "government-to-government" relationship based on the U.S. Constitution, treaties, Federal statutes, court decisions, and Executive Branch policies, as well as moral and ethical considerations. This special relationship also constitutes a trust relationship between these two governments. Certain benefits provided to Indian people through Federal legislatively enacted programs flow from this trust relationship. These benefits are not based upon race, but rather, are derived from the government-to-government relationship. A vital component of this relationship is consultation between the Federal and tribal governments. In cases where the government-to-government relationship does not exist, as with urban Indian centers, Inter-tribal organizations, state recognized tribal groups, and other Indian organizations, consultation is encouraged to the extent that there is not a conflict-of-interest in the above stated Federal statutes or the Operating Division/Staff Division (OPDIV/STAFFDIV) authorizing legislation. Some aspects of this consultation are set out in statute and administrative policy.

II. FOUNDATIONS

A. Federally Recognized Tribes

The special relationship between the U.S. government and tribal governments is grounded in many historical, political, legal,

moral, and ethical considerations. Increasingly this special relationship has emphasized self-determination for Indian people and meaningful involvement by Indian people in Federal decision making (consultation) where such decisions affect Indian people, either because of their status as Indian people or otherwise.

Consultation examples include:

1. A provision in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, codified at 25 U.S.C. 450a states that:
  - (a) Congress . . . recognizes the obligation of the United States to respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of . . . Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities."
  - (b) The Congress declares its commitment to the maintenance of the Federal government's unique and continuing relationship with, and responsibility to, individual Indian tribes and Indian people as a whole through . . . effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services."
2. Regulations implementing the Indian Self-Determination Act, as amended, contain the following provisions:

25 C.F.R. 900.3(a)(2): " Congress has declared its commitment to the maintenance of the Federal government's unique and continuing relationship with, and responsibility to, individual Indian tribes and to the Indian people as a whole through the establishment of meaningful Indian self-determination policy which will permit an orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct and administration of those programs and services ."

25 C.F.R. 900.3(b)(1): "It is the policy of the Secretary to facilitate the effort of Indian tribes and tribal organizations to plan, conduct, and administer programs, functions, services and activities, or portions thereof, which the departments are authorized to administer for the benefit of Indians because of their status as Indians . . . ."
3. The Indian Health Care Improvement Act, P.L. 94-437,

contains a "Congressional Finding[]," codified at 25 U.S.C. 1601, that:

"(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."

4. The Unfunded Mandates Reform Act of 1995, P.L. 104-4, states:

Section 2. "The purposes of this Act are . . . to assist Federal agencies in their consideration of proposed regulations affecting . . . Tribal governments by . . . requiring that Federal agencies develop a process to enable . . . Tribal governments to provide input when Federal agencies are developing regulations, and requiring that Federal agencies prepare and consider the budgetary impact of Federal regulations containing Federal mandates upon . . . Tribal governments before adopting such regulations."

5. The President's Memorandum of April 29, 1994, to heads of executive departments and agencies titled, "Government-to-Government Relations with Native American Tribal Governments," outlines the concepts of consultation (Attached).

#### B. Non Federally Recognized Tribes and Other Native American People

Indian people are often significantly or differentially affected by the Department of Health and Human Services (HHS) actions, may have special needs that HHS policy makers may not be sensitive to, may make especially valuable contributions to policy formulation and program administration because of their unique perspectives, and may be expressly mentioned in HHS statutes, or need to be effectively and efficiently served as a part of the HHS' mission.

Although the special "tribal-federal" relationship is based in part on the government-to-government relationship, other statutes and policies exist that allow for consultation with non-federally recognized tribes and other Indian organizations that, by the mere nature of their business, serve Indian people and might be negatively affected if excluded from the consultation process. Specifically:

1. A statute administered by the Indian Health Service (IHS), 25 U.S.C. 1653, requires the Secretary of HHS to enter into

contracts with or issue grants to urban Indian organizations to assist such urban centers for the provision of health care and referral services for urban Indians residing in the urban centers in which such organizations are situated. (42 U.S.C. 1654 authorizes grants and contracts with urban Indian organizations to determine the health status and unmet health needs of urban Indians.)

2. A statute administered by the Administration for Native Americans (ANA), Sec. 802. [42 U.S.C. 2991b], provides financial assistance for Native American projects including but not limited to, governing bodies of Indian tribes on Federal and State reservations, Alaska Native villages and regional corporations established by the Alaska Native Claims Settlement Act, and such public and nonprofit agencies serving Native Hawaiian, and Indian and Alaska Native organizations in urban and rural areas that are not Indian reservations or Alaska Native villages, for projects pertaining to the purposes of this title. The Commissioner is authorized to provide financial assistance to public and nonprofit private agencies serving other Native American Pacific Islanders (including American Samoan Natives) for projects pertaining to the purposes of this act. In determining the projects to be assisted under this title, the Commissioner shall consult with other Federal agencies for the purposes of eliminating duplication or conflict among similar activities or projects and for the purpose of determining whether the findings resulting from those projects may be incorporated into one or more programs for which those agencies are responsible. Every determination made with respect to a request for financial assistance under this section shall be made without regard to whether the agency making such request serves, or the project to be assisted is for the benefit of, Indians who are not members of a federally recognized tribe . . . . The statute (42 U.S.C. 2991b-2(c)(2)) also requires that the Administration for Native Americans (ANA) Commissioner, "serve as an effective and visible advocate for Native Americans . . . ;" while 42 U.S.C. 2991b-2(d) establishes, in the Office of the Secretary, the Intra-Departmental Council on Native American Affairs. Among its responsibilities, 42 U.S.C. 2991b-2(c)(3) requires that this Council assist the Commissioner in "coordinating activities within the department leading to the development of policies, programs, and budgets, and their administration that directly affect Indian and other Native populations . . . ."

3. A statute administered by the Administration for Children and Families that establishes the Low Income Home Energy Assistance Program (42 U.S.C. 8621 et seq.) and its implementing regulations (45 C.F.R. 96.48) make clear that

Federal and State recognized tribes may receive direct funding under this block grant.

A statute administered by the Health Resources and Services Administration that establishes the Centers of Excellence in the Minority Health Program (42 U.S.C. 293c(c)(4), (d)(3), (e)) provides for the funding of programs in health professions education at Native American Centers of Excellence.

Other HHS components that rely on more general statutory consultation language conduct activities that directly affect Indian people.

### XII. THE DOMESTIC POLICY COUNCIL (DPC) WORKING GROUP ON AMERICAN INDIAN/ALASKA NATIVE AFFAIRS CONSULTATION PROCESS

In response to the President's 1994 Memorandum, the DPC's Working Group on Indian Affairs led by the Secretary of the Interior established a subgroup to develop a consultation policy. After nearly 2 years of analysis and deliberations toward devising a uniform, Government-wide consultation policy, the DPC concluded that such uniformity was undesirable given the different organizational structures, statutory considerations and administrative processes between Federal departments and agencies. Therefore, the DPC recommended that each department be charged with developing its own individualized consultation policy/plan. The DPC drafted guidelines identifying six points that should be addressed by each department's consultation policy/plan:

1. Each department will develop a general department-wide AI/AN policy/plan that outlines its general direction on consultation.
2. Each department will develop its own methods of consultation based on its internal requirements using tools that it has available.
3. As part of the decision-making process for major issues that affect AI/ANs, each department will develop a short "consultation plan" that will indicate to tribal governments how, for example, consultation in general, and time frames would be carried out on a particular issue.
4. Each department will include an appropriate plan for the receipt of input, allowing for adequate response time, on AI/AN appropriation needs before the department submits its fiscal budget to the Office of Management and Budget. Each department should encourage tribal government input in its budget formulation process so that it may be useful to their

decision-making.

5. Each department will utilize either the Codetalk Home Page or its own Home Page (with a link to Codetalk) to make its consultation plan known to the tribes and the public. Each department should also use its Home Page to solicit tribal government comments on its consultation plan. Finally, each department should have its own American Indian/Alaska Native Policy Statement available at the same Home Page source.
6. Each "consultation plan" should include sufficient time and access so that tribes may provide input before a final decision is made.

#### IV. HHS AI/AN CONSULTATION PROCESSES AND RECOMMENDATIONS

The DPC's recommendations on departmental policy formulation led to the creation of an HHS Working Group on Consultations with American Indians and Alaska Natives. Co-chaired by Jo Ivey Boufford, M.D., former Acting Assistant Secretary for Health, and Michael H. Trujillo, M.D., Director, Indian Health Service (IHS). This group is comprised of representatives from the department's major Operating Divisions and Office of the Secretary Staff Divisions (OPDIV/STAFFDIV). During several meetings, the group explored the broad array of AI/AN programs within the department that resulted in a departmental report, "Improving the Health and Well-Being of American Indians and Alaska Natives." This report is a summary of each OPDIV/STAFFDIV's 1995-1996 activities and/or programs for AI/AN people.

The HHS Working Group also reviewed each OPDIV/STAFFDIV's current approach(es) to consultation, and worked to develop recommendations for a departmental approach to consultation that could be forwarded to the Secretary. The working group recommended that the department's Consultation Plan consist of the individual OPDIV/STAFFDIV plans and any department-wide consultation processes as deemed necessary.

#### V. RECOMMENDATIONS

##### A. HHS APPROACH TO CONSULTATION

Based on the HHS Working Group deliberations and review of work accomplished by IHS, the following definition of "consultation" is proposed for HHS use:

"Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and

comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making."

It is recommended that the policy of this Department be:

1. To consult with Indian people to the greatest practicable extent and to the extent permitted by law before taking actions that affect these governments and people;
2. To assist States in the development and implementation of mechanisms for consultation with their respective tribal governments and Indian organizations before taking actions that affect these governments and/or the Indian people residing within their state. Consultation should be conducted in a meaningful manner that is consistent with the definition of "consultation" as defined in this policy, including reporting to the appropriate HHS agency on its findings, and on the results of the consultation process that was utilized;
3. To assess the impact of this Department's plans, projects, programs and activities on tribal and other available resources;
4. To remove any procedural impediments to working directly with tribal governments or Indian people; and
5. To work collaboratively with other Federal agencies in these efforts.

#### B. DEPARTMENTAL-LEVEL ACTIONS

1. Consistent with the thrust of the DPC guidance on budget consultation, it is recommended that the Office of Intergovernmental Affairs (IGA), IHS, ANA, and the Office of Minority Health (OMH), convene for the department, an annual meeting of Indian people to present their appropriation needs and priorities. The OPDIVs and STAFFDIVs are encouraged to suggest participants that should be included in attendance. This meeting should take place before the submission by OPDIVs/STAFFDIVs of their budget requests to the department (probably in May of each year). The Assistant Secretary for Management and Budget and other appropriate OPDIVs/STAFFDIVs will have representatives at this meeting to ensure that these needs and priorities are made known to the members of the department's Budget Review Board.

Before the annual meeting, a brief, clear document

summarizing the preceding year's departmental budget should be made available as a basis for discussion to all potential consultation participants. Before or after this meeting, OPDIVs/STAFFDIVs who wish to conduct consultation on the fiscal year budgets specific to their programs or other OPDIV/STAFFDIV activities relevant to AI/AN, are encouraged to do so (the proposed approach should be outlined in the specific OPDIV/STAFFDIV consultation policy/plan).

2. The department should determine if there are other issues or priorities for legislation or cross cutting initiatives that require department level consultation and develop a process for such consultation, otherwise, the processes developed by each OPDIV/STAFFDIV should be aggregated as the departmental process and communicated appropriately.
3. The department will designate a single point-of-contact that can provide AI/AN representatives with access to departmental program information and assistance. This function will be located in the OS/IGA, linked to HHS Regional Offices for field follow-up/contact.

#### C. OPDIV/STAFFDIV LEVEL ACTIONS

##### RECOMMENDATIONS:

1. Each OPDIV should prepare a draft policy/plan for a consultation process. The OS should be considered an OPDIV for these purposes so that STAFFDIVs may consult as a group and develop an integrated, cross-cutting consultation process. This draft will be reviewed by the Working Group for comment and by the Office of the General Counsel for any legal issues. The Assistant Secretary for Management and Budget would be considered the lead for the annual Department-wide budget consultation described above.
2. Each OPDIV (and STAFFDIV) should consult with AI/AN leaders on their "reviewed" policy/plan (see IHS "Tribal Consultation and Participation Policy," (Attachment A).
3. Each OPDIV (and STAFFDIV) policy/plan should include:

A specific delineation of the issues on which advice/consultation will be sought or criteria that will be used to identify the issues. In general, budget matters and legislation affecting tribes are considered critical for consultation. The OPDIVs/STAFFDIVs which have difficulty with this item may wish to conduct a focus group of AI/AN representatives to recommend the kinds of items on which consultation should be conducted.

A provision that seeks to ensure that the OPDIV/STAFFDIV will assist States in the development and implementation of mechanisms for consultation with their respective tribal governments and Indian organizations before taking actions that affect these governments and/or the Indian people residing within their State. Consultation should be conducted in a meaningful manner that is consistent with the definition of "consultation" as defined in this policy, including reporting to the appropriate HHS agency on its findings, and on the results of the consultation process that was used.

A mechanism by which the OPDIV/STAFFDIV will evaluate the States efforts in compliance with the consultation process with tribal governments and Indian organizations.

Guidelines that define how the OPDIV/STAFFDIV will address States in situations where the evaluation has identified deficiencies in the consultation process as set forth in this policy.

A defined process for early inclusion of tribal governments and other Indian people in the decision-making process;

Specific mechanisms that will be used to consult with tribal governments. In consultation with tribal governments and other Indian people, the decision could be made to use IHS or other mechanisms such as intermediate national or regional organizations and conferences, or establish specific structures for ongoing advice from Indian communities.

4. Consultation process: Further, each OPDIVs/STAFFDIVs plan should also provide:

Sufficient background information to assure a thorough understanding of each issue on which consultation is requested, including a clear statement of the potential impact of the proposed action on Indian people.

A clear statement of the advice requested.

A specific time frame for response from consulted entities.

A clear indication of who should receive the reply.

5. Upon completion of consultation, there may be issues that would benefit from ongoing involvement of Indian people in implementation and evaluation. The OPDIV/STAFFDIV plans should include mechanisms to address this need.

Timely feedback should be provided to Tribes and Indian organizations on the resolution of the issue for which consultation was requested.

6. The consultation process when finalized should be displayed on the OPDIV/STAFFDIV's Home Page and on OMH's Association of American Indian Physicians (AAIP) Home Page, which already connects to the IHS Home Page and should be connected to the HHS and Codetalk Home Pages. It was noted that assuring adequate consultation may require the investment of resources by the OPDIVs/STAFFDIVs, such as provision of training, detailing of staff or providing information technology to tribal governments and other Indian people. In instances where computer capabilities are absent, OPDIVs/STAFFDIVs should attempt to disseminate information by other media mechanisms such as the telephone, newspaper, magazines, newsletters, etc.
7. Establishment of a single point-of-contact for tribal governments and other Indian people within each OPDIV/STAFFDIV at a level with access to information of all the OPDIVs/ STAFFDIVs operating components and programmatic levels is recommended. This will assist the department's point of contact in the IGA in accessing department-wide information and aid in providing a single entry point to HHS-wide information.
8. Each OPDIV/STAFFDIV will submit to the IGA by December 31 an annual report on the previous fiscal years consultation activities addressing how each point in their plan was implemented for each consultation conducted.

## VI. SUMMARY

We have endeavored to consider a wide range of OPDIV/STAFFDIV needs and unique characteristics in crafting these guidelines. As there is variability among the OPDIVs/STAFFDIVs, there is also a need to allow for variability over time. Hence, it is important that consultation plans developed by OPDIVs/STAFFDIVs remain dynamic, changing as circumstances and AI/AN input indicate. Once the Department has its basic consultation policy in place, it should seek to integrate its efforts with those of other departments and agencies. Such intra-governmental coordination will benefit the departments and agencies as well as AI/ANs.

TRIBAL CONSULTATION PLAN  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Office of the Secretary – Staff Divisions

1. INTRODUCTION

The United States (U.S.) government and the governments of American Indians and Alaska Natives (AI/AN or Indian people) have a unique government-to-government relationship based on the U.S. constitution, treaties, Federal statutes, court decisions, and Executive Branch policies, as well as moral and ethical considerations. Increasingly this special relationship has emphasized self-determination for Indian people and meaningful involvement by Indian people in federal decision making (consultation) where such decisions affect Indian people, either because of their status as Indian people or otherwise.

Consistent with these principals, the President issued an Executive Memorandum on April 29, 1994, titled, "Government-to-Government Relationship with Native American Tribal Governments." This Memorandum states that in all activities relating to or affecting the government or treaty rights of Indian tribes, the executive branch shall:

- a. operate within a government-to-government relationship with federally recognized Indian tribes;
- b. consult, to the greatest extent practicable and permitted by law, with Indian tribal governments before taking actions that affect federally recognized Indian tribes;
- c. assess the impact of agency activities on tribal trust resources and assure that tribal interests are considered before the activities are undertaken;
- d. remove procedural impediments to working directly with tribal governments on activities that affect trust property or governmental rights of the tribes; and
- e. work cooperatively with other agencies to accomplish these goals established by the President.

The President issued Executive Order 13084, dated May 14, 1998 and titled "Consultation and Coordination with Indian Tribal Governments", to establish regular and meaningful consultation and collaboration with Indian tribal governments:

- a. in the development of regulatory practices on Federal matters that significantly or uniquely affect their communities;
- b. to reduce the imposition of unfunded mandates upon Indian tribal governments; and

- c. to streamline the application process for and increase the availability of waivers to Indian tribal governments.

On August 7, 1997, the Secretary, Department of Health and Human Services (HHS) issued a memorandum establishing the HHS policy on consultation with American Indian/Alaska Native Tribes and Indian organizations. In addition to establishing HHS wide policy, this memorandum directed each agency to develop their own individualized consultation plan consistent with HHS policy.

Consultation examples include:

- a. Departmental regulations implementing the Indian Self-Determination Act, as amended, such as: "It is the policy of the Secretary to facilitate the effort of Indian tribes and tribal organizations to plan, conduct, and administer programs, functions, services and activities, or portions thereof, which the departments are authorized to administer for the benefit of Indians because of their status as Indians..."
- b. Federal laws such as the Unfunded Mandates reform Act of 1995, P.L.104-4, which states: "The purposes of this Act are...to assist Federal agencies in their consideration of proposed regulations affecting...Tribal governments by...requiring that Federal agencies develop a process to enable...Tribal governments to provide input when Federal agencies are developing regulations, and requiring that Federal agencies prepare and consider the budgetary impact of Federal regulations containing Federal mandates upon...Tribal governments before adopting such regulations (Sec.2)."

## 2. PURPOSE

To establish an Office of the Secretary (OS) Staff Division (STAFFDIV) policy on consultation with AI/AN tribal governments; reaffirm the STAFFDIV recognition of the sovereign status of federally recognized Indian tribes; to reaffirm adherence to the principles of government-to-government relations; to inform Staff division personnel, other federal agencies, federally recognized Indian tribes, Indian organizations, and the public of the STAFFDIV working relationships with federally recognized Indian tribes.

## 3. DEFINITION

Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which lead to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making.

#### 4. STAFFDIV PARTICIPATION IN DEPARTMENT ACTIONS

STAFFDIVs share numerous common characteristics. Their similar missions, goals, operations, and resources are distinct from those of the Department's Operating Divisions (OPDIVs). Based on the shared characteristics of the STAFF/DIVs, and their distinction from the OPDIVs, the Tribal Consultation Working Group requested that the STAFFDIVs develop an integrated response to the initiative.

The STAFFDIVs are responsible for administration, policy development and analysis, budget recommendations and justification, information management, intergovernmental relations, monitoring of program quality, prevention and detection of fraud, waste, and abuse, and other personnel intensive activities for the entire Department. In general, OS STAFFDIVs have no direct responsibilities for grant making, health or social services delivery, or related program activities.

Consistent with the HHS policy, STAFFDIVs will maintain a list of suggested AI/AN participants to attend consultation meetings or subject matter/expert roundtables or forums convened for the department.

The OS will coordinate with other agencies in determining other issues or priorities for legislation or cross cutting initiatives that require department level consultation.

The OS designated single point of contact for program information and assistance will be the Senior Advisor on American Indian and Alaskan Native Affairs, in the Office of Intergovernmental Affairs (OIGA).

#### 5. OS LEVEL ACTIONS

- a. With advice and consultation from tribal governments, OIGA will work with the STAFFDIVs to identify critical events at which tribal consultation and participation will be required. This will be accomplished within 120 days of approval of this plan.

Although the principal focus for consultation and participation activities of OS is with individual tribal governments, it is important that OS solicit advice and involvement from nation Indian organizations and other AI/AN organizations interested in issues affecting AI/ANs.

Focus group sessions will be held to solicit official tribal comments and recommendations on legislation and budget matters affecting AI/ANs. Issue sessions at roundtables, forums, and meetings will provide the opportunity for meaningful and effective participation by AI/AN officials and organizations in the planning of the OS functions and services.

The Government Performance and Results Act (GPRA) is intended to help Federal programs succeed by identifying what constitutes successful program performance, what resources are needed and what challenges exist which affect achieving success.

GPRA also requires accountability. Consultation with AI/AN will assure that the OS functions achieve success.

- b. OIGA will coordinate with OPDIVs to assist states in developing mechanisms for consultation with their AI/AN governments and Indian organizations before taking any actions that affect these governments and/or Indian people. States will receive assistance in developing state plan assurances for the delivery of services to AIs/ANs.

State consultation with AI/AN should be done in a meaningful manner that is consistent with the definition of "consultation" as defined in this policy plan.

OIGA will assure that State plans on consultation with AI/AN are successful by convening conferences with States, AI/AN tribes and organizations, to develop a set of consultation protocols. The developed protocols will be used in the evaluation of States efforts to consult with AI/AN governments and organizations. Technical assistance and monitoring will be provided by Regional Office staff.

Specific mechanisms that will be used to consult with tribal governments are: mailings, meetings, teleconferences, and roundtables.

- c. The Assistant Secretary for Management and Budget (ASMB) and the OIGA have established an annual Department-wide budget consultation meeting to bring tribal representatives together with HHS policy officials providing these representatives with an opportunity to present their appropriation priorities. These meetings have taken place in the Spring, before the OPDIVs and STAFFDIVs submit their budget requests to the Department.
- d. The OIGA upon completion of a consultation will determine if there are any unresolved issues that would benefit from ongoing involvement of AI/AN tribal governments in implementation and evaluation. The OIGA will include a mechanism to address this need.
- e. The OIGA will consult with AI/AN leaders on the "reviewed" policy/plan to provide for effective and meaningful participation by AI/AN.
- f. The single point of contact within the OIGA for tribal governments and other Indian people, at a level with access to all OPDIVs/STAFFDIVs, is the Senior Advisor on American Indian and Alaska Native Affairs. This office will serve as the department's point of contact in accessing department-wide information.
- g. The HHS consultation policy and implementation plans will be posted on the HHS website homepage, appropriate American Indian websites, and published in the Federal Register soliciting comments. Tribes will be given access to HHS consultation with sufficient time to respond before any final decisions are made.
- b. The OIGA will continue to inform tribal leaders on consultation policy by holding

meetings, roundtables, teleconferences, forums, and placing information on the HHS website homepage and other appropriate websites.

**SUMMARY:**

The OIGA considers consultation an evolving process. The HHS' central and regional offices have established relationships with Tribal governments and Indian organizations with which they communicate about HHS programs. This joint partnership will ensure implementation of the consultation plan, allow recommendations for revisions based on periodic assessments, and assure that Tribal issues are promptly addressed.



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

V

TO: All Staff

FROM: The Secretary

SUBJECT: New Role for the Assistant Secretary for Health

As you know, pursuant to our Reinvention of Government and streamlining processes, I have merged the Office of the Assistant Secretary for Health (OASH) with the Office of the Secretary (OS), creating a unified corporate headquarters for the Department that brings expertise in public health and science closer to the Secretary.

The merger creates a new role for the Assistant Secretary for Health (ASH), who becomes head of the Office of Public Health and Science (OPHS), a new division within OS. The Public Health Service (PHS) agencies become HHS Operating Divisions, reporting directly to the Secretary. These Operating Divisions, along with the new OPHS, continue to constitute the U.S. Public Health Service, with the Secretary of Health and Human Services as its head.

The ASH will have a distinctive role within the OS, leading an office defined by a substantive area rather than by a function. The ASH will, by necessity, have a "hybrid" role, acting as senior advisor for public health and science to the Secretary and providing senior professional leadership in the Department on population-based public health and clinical preventive services. In addition, the ASH will exercise certain operational responsibilities under my direction by: directing program offices within the OPHS; providing professional leadership on cross-cutting Departmental public health and science initiatives; and, at the direction of the Secretary, providing assistance in managing the implementation of Secretarial decisions for the Public Health Service Operating Divisions.

To perform this role the ASH will:

Function as the Secretary's senior advisor for public health and science by:

- serving as the senior professional representative to the public health and science communities;
- serving as the senior professional representative on public health and science related interagency and interdepartmental task forces and as the liaison with the White House Office of Science and Technology Policy;
- serving as the senior professional spokesperson on public health and science issues;

- providing advice to the Secretary in the review of budget and legislative proposals related to public health and science;
  - assisting the Secretary in developing a policy agenda for the Department to address major population-based public health, prevention and science issues; and,
  - fulfilling emergency preparedness leadership responsibilities in health.
2. Provide leadership and, as directed by the Secretary, serve as the focal point for coordination across the Department in public health and science by:
- assuring that the Department conducts broad-based public health assessments designed to anticipate future public health issues and problems and to assure that the Department devises and implements appropriate interventions and evaluations to maintain, sustain and improve the health of the Nation;
  - providing assistance in leading and managing the implementation and coordination of Secretarial decisions for PHS operating divisions, and, for that purpose, drawing on staff divisions and other units for assistance in regard to legislation, budget, communications, and policy analysis;
  - providing leadership and a focus for coordination of population-based health, clinical preventive services and science initiatives that cut across operating divisions;
  - providing leadership for and management of the OPHS that will consist of the following OS offices:
    - Office on Women's Health
    - Office of Minority Health
    - Office of Emergency Preparedness
    - Office of Population Affairs
    - Office of International and Refugee Health
    - Office of Disease Prevention and Health Promotion
    - President's Council on Physical Fitness and Sports
    - Office of Research Integrity
    - Office of HIV/AIDS Policy
    - Office of the Surgeon General
  - providing leadership and coordination with the Office of International Affairs on international health issues and representation to foreign governments and multi-lateral agencies on health issues.

Page Three

3. Through the Surgeon General, provide direction of and policy setting oversight for the Commissioned Corps as well as providing the organizational base for the Surgeon General's exercise of statutory and assigned responsibilities.
4. Assure that the PHS mission is carried out in concert with the Department's overall mission by chairing the new Public Health Council.

I have asked Dr. Lee to develop a charter for the Council that will allow it to serve as a forum for coordinating the leadership of the new Public Health Service and other components of the Department, as appropriate, to advise me on cross-cutting public health issues and activities.

This is a time of major change in the management of the Department and of the Nation's health sector. I am aware that, as with any new organizational arrangement, questions and issues arise because of the unanticipated effects of change. I know that everyone will work to resolve any problems in a collaborative manner. I am committed to strengthening public health and science programs in the Department and believe that the reinvented organization and the new responsibilities of the ASH are essential to achieving that end.

A handwritten signature in black ink, appearing to read 'Donna E. Shalala', with a long horizontal flourish extending to the right.

Donna E. Shalala



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

Dear

As you may know, an important change intended to improve our effectiveness in the area of public health has been made in the management structure of the Department of Health and Human Services.

As part of our Departmentwide efforts under the Reinvention of Government initiative, I have merged the Office of the Assistant Secretary for Health (OASH) with the Office of the Secretary (OS), creating a unified corporate headquarters for the Department that brings expertise in public health and science closer to the Secretary.

This merger creates a new role for the Assistant Secretary for Health (ASH), who becomes head of the Office of Public Health and Science (OPHS), a new division within the Office of the Secretary. The Public Health Service (PHS) agencies each become full HHS Operating Divisions, reporting directly to the Secretary. These Operating Divisions, along with the new OPHS, continue to constitute the U.S. Public Health Service.

The ASH will carry out a number of roles. Among these, he or she will be the Department's senior professional representative to the public health and science communities. The ASH will also serve as senior public health and science advisor to the Secretary, provide senior professional leadership in the Department on population-based public health, direct the program offices within the OPHS, and at my request, provide assistance in managing the implementation of Secretarial decisions relating to cross-cutting issues involving the Public Health Service Operating Divisions.

The enclosed memorandum explains in more detail the new role which the ASH will play. As always, the coordination of our efforts with those outside the federal government will be crucial, and the ASH will continue to be vital in providing that liaison. We will be anxious to answer any questions you may have about the restructured Department of Health and Human Services, and we look forward to our continuing work with you toward better health for our citizens.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Shalala", with a long horizontal flourish extending to the right.

Donna E. Shalala

Enclosure

**PROPOSED LIST**  
**Individuals and Organizations to Receive a Letter**  
**FROM THE SECRETARY**  
**Announcing the New Role of the ASH**

Letters from the Secretary, addressed to the President/CEO:

B. Professional Associations/Organizations

American Academy of Family Medicine  
American Academy of Pediatrics  
American Cancer Society  
American Chiropractic Association  
American College of Physicians  
American College of Surgeons  
American College of Obstetricians and Gynecologists  
American Dental Association  
American Heart Association  
American Hospital Association  
American Medical Association  
American Nurses Association  
American Occupational Therapy Association  
American Osteopathic Association  
American Public Health Association  
American Pharmaceutical Association  
American Physical Therapy Association  
American Psychiatric Association  
American Psychological Association  
American Speech Language Hearing Association  
Association of Academic Health Centers  
Association of American Medical Colleges  
Association of Schools of Allied Health Professions  
Association of State and Territorial Health Officials  
Council on Social Work Education  
Federation of Associated Schools of Health Professions  
Health Industry Manufacturers Association  
Institute of Medicine  
National Academy of Sciences  
National Association of Social Workers  
National Association of State Alcohol and Drug Abuse  
Directors, Inc.  
National Association of State Mental Health Program  
Directors  
National Black Nurses Association  
National Medical Association  
National Association of Community Health Centers  
National Association of County and City Health Officials  
National Governors Association  
New York Academy of Medicine  
PROPAC  
Physician Payment Review Commission

Letters from the Secretary, Page Two

II. Congressional Letters - to be cleared with ASL/ASMB

Senate Leadership

Senate Majority Leader, Senator Robert Dole  
Senate Minority Leader, Senator Thomas A. Daschle

House Leadership

Speaker of the House, Newt Gingrich  
House Majority Leader, Dick Armey  
House Minority Leader, Richard A. Gephardt

Senate Finance Committee

Chairman William V. Roth  
Daniel P. Moynihan, Ranking Minority Member

House Ways and Means

Chairman Bill Archer  
Sam M. Gibbons, Ranking Minority Member

Subcommittee on Health

Chairman William M. Thomas  
Pete Stark, Ranking Minority Member

House Committee on Commerce,

Chairman Thomas J. Bliley  
John D. Dingell, Ranking Minority

Subcommittee on Health and Environment

Chairman Michael Bilirakis  
Henry A. Waxman, Ranking Minority Member

Senate Committee on Labor and Human Resources

Chairman Nancy Landon Kassebaum  
Edward M. Kennedy, Ranking Minority Member

House Committee on Appropriations

Chairman Bob Livingston  
David Obey, Ranking Minority Member

Labor, HHS, Education and Related Agencies Subcommittee

Chairman John Edward Porter  
David Obey, Ranking Minority Member

Letters from the Secretary, Page Three

Dr. Lee had suggested writing to all members of this subcommittee:

C.W. Bill Young  
Henry Bonilla  
Ernest Jim Istook  
Dan Miller  
Jay Dickey  
Frank Riggs  
Roger F. Wicker

Louis Stokes  
Steny H. Hoyer  
Nancy Pelosi  
Nita M. Lowrey

Senate Appropriations Committee

Chairman Mark O. Hatfield  
Robert C. Byrd, Ranking Minority Member

Labor, Health and Human Services, Education And  
Related Agencies Subcommittee

Chairman Arlen Specter  
Tom Harkin, Ranking Minority Member

Senate Committee on Government Affairs

Chairman Ted Stevens  
John Glenn, Ranking Minority Member

House Government Reform and Oversight Committee

Chairman William F. Clinger  
Cardiss Collins, Ranking Minority Member

Additional Congressional letters:

Senator Barbara Boxer  
Senator Kent Conrad  
Senator Dianne Feinstein  
Senator Daniel Inouye  
Senator Bob Kerry  
Senator John D. Rockefeller, IV

### III. Foundations

Kellogg Foundation  
Kaiser Family Foundation  
Pew Charitable Trust  
R.W. Johnson Foundation

Letters from the Secretary, Page Four

Grantmakers in Health  
Blue Cross (California)  
Carnegie Foundation  
Rockefeller Foundation  
Ford Foundation  
Commonwealth Fund  
Edna McConnell Clark

IV. Others

National Indian Health Board, Julia Davis, Chairperson

National Congress of American Indians

National Health Council

Coalition of Hispanic Health and Human Services Orgnaization



THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

AUG 1 - 1995

MEMORANDUM TO: OPDIV and STAFFDIV HEADS

SUBJECT: OS/OASH Merger

The House Appropriations Committee has proposed substantial reductions in the budgets of the Office of the Secretary and the Office of the Assistant Secretary for Health. The Committee also assumed the merger of OS and OASH, as well as imposing other serious financial constraints. These actions pose serious challenges for us, but if we work together I am confident we can respond constructively with a minimum of dislocation. It is critically important that we act supportively for our employees and the people we serve. While this funding bill may be substantially changed in the Senate, we nevertheless need to move quickly so we are not placed in an untenable stance of having large numbers of unfunded positions on October 1. The purpose of this memorandum is to get a process in place that will assist the Secretary as she makes further decisions in the coming weeks.

Background.

The Committee's recommendations would move \$3 million in funding for OASH into the OS General Departmental Management account. They would eliminate funding for approximately 250 of the 450 FTE now funded by the OASH appropriation, and for about 160 FTE out of 1200 FTE now funded by the OS GDM and OCR appropriations. Additionally, the IG does not have adequate funds to support current FTE streamlining targets. Of the 200 OASH FTE that are funded by the Committee recommendations, approximately 170 are designated for specific purposes (Office of Population Affairs, President's Council on Physical Fitness and Sports, Office of Minority Health, Office of Research Integrity, Office of Women's Health). This means that only 30 of the OASH FTE funded by the Committee are available to OS for performance of other OASH functions, whether within the new ASH or elsewhere in OS. I believe the reductions we need to accomplish, though difficult, can be achieved without Reductions in Force. All of us need to do everything possible to fulfill the Secretary's pledge to avoid RIFs.

Action.

I have requested OASH leadership to take several immediate steps.

First, I have asked OASH to make recommendations for the minimum essential OASH functions that need to be retained in the new OS, and I will suggest to the Secretary that she consider these recommendations together with those that emerge from the OS staff divisions, as described below.

Second, I have asked OASH to examine those current OASH functions that do not require a presence in the OS and to make recommendations for possible placement of these functions in the health agencies or in a Program Support Center (PSC). For those appropriated fund staff who would move to the PSC when it is created, plans should be made for immediate placement so they are funded either by the Service and Supply Fund or the OS-Working Capital Fund using existing vacancies.

Finally, I have instructed OASH to begin immediately the process of finding placements for OASH staff in PHS agencies. This is a vital step that has to start now if we are to avoid RIFs.

Simultaneously, I am requesting that each OS staff division head work with his or her counterpart in OASH to make a rigorous examination of current staffing in OS and OASH, and make a recommendation for a very lean merged office. This is a difficult effort to ask people to undertake, but it is unfortunately necessary that we do this, given the recent Committee action. I expect the recommended merged offices will in most instances be significantly smaller than the sum of the current OS and OASH parts. We need to retain essential expertise and capacity not only from OS but also from OASH. This assignment includes Public Affairs, Communications, Legislation, Planning and Evaluation, Intergovernmental Affairs, Management and Budget, International Health, Executive Secretariat, and Personnel. Again, I know this is hard, but it is vitally important and I know everyone will proceed quickly.

As part of this process, I would also ask OS and OASH to review and refine staff levels for those functions that have been identified for placement in the Program Support Center. This issue needs to be re-examined in light of the House Committee action.

To accomplish these difficult tasks, each OS division head needs also to examine his or her current staffing closely, and to consider ways to reduce it. The fact is that reductions in current OS staffing levels would be required by the House Appropriations Committee recommendations even if OS were not simultaneously assuming new responsibilities in the public health area.

While mutually agreed upon reassignments are the way we want to go whenever we can, directed reassignment from OS divisions to operating divisions is a tool that we may need to use as well. Operating division heads should also be aware that such reassignments may be necessary. OASH might also find it necessary to use directed reassignment within PHS, although, again, that should not be the preferred approach.

I recognize that these requests are extremely painful. We have no choice but to be in a position to achieve staffing reductions in the combined OS and OASH by October 1, in case the House

Appropriations Committee recommendations become law, or become the basis of operations under a continuing resolution. The steps I am requesting will help the Secretary in her decision-making process and help all of us to make the necessary reductions in a planned fashion, both protecting our employees and also maintaining a strong Office of the Secretary.

Several iterations of these steps will probably be necessary, and it is important that we move very quickly, particularly because this is such a complex undertaking. Accordingly, I request your responses by close of business on Friday, August 11. These responses should include a first cut at the definition of the new merged offices and a plan with timetables to be developed by OS and OASH human resources staff that will guide our work in managing and monitoring the outplacement process.

Thank you for your cooperation. I know we will undertake this effort in the same spirit of collegiality that has characterized all of our work together.



Walter D. Broadnax

Reinventing HHS, OS/OASH Merger -- REGO II (07/06/95)

THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

MEMORANDUM FOR ALL DHHS EMPLOYEES

SUBJECT: REGO II--Reinventing OS and OASH

I would like to update you on the progress of the REGO II initiative which calls for merging the Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH), and to let you know of two important decisions I have made regarding the merger.

First, the PHS agencies will become operating divisions reporting directly to the Secretary. Second, the Assistant Secretary for Health (ASH) will become a staff position within OS, providing leadership, expertise, and key advice to the Secretary on health and science issues, but not retaining line management responsibilities for the PHS agencies. These changes will both strengthen the PHS agencies and create a stronger headquarters unit for the Department. I am confident that the new organizational structure will greatly benefit the Department, and more importantly, the people we serve.

Of course there are many additional issues to be addressed and we will continue to keep you informed as we move forward. Attached to this message is the second edition of "OS/OASH News," which provides information on how the OS/OASH implementation planning team, led by Assistant Secretaries Lee and Ellwood, is carrying out its work.

/s/  
Donna E. Shalala

\*\*\*\*\*

REGO II NEWS AT YOUR FINGER TIPS

The first edition of REGO II News, which incorporates the "OS/OASH News" edition referenced in the Secretary's memorandum above, has been released and is immediately available to you from the HHS News Center. To obtain your copy of REGO II News we have made it even easier for you--just pay careful attention to the following instructions:

Reply to this message and type the following in the Subject Line (PRCFs users can place this on the first line of the message area):  
GETNEWS REG1 if you have WordPerfect, or GETNEWS REG1.DOS if you do not. In a matter of minutes a copy of REGO II News will be sent to you as an "attached" file. If you do not know how to read or download an attached file on your e-mail system, please ask your computer systems or administrative staff for assistance.

Here's what you'll find in this issue of REGO II News:

REGO II NEWS HIGHLIGHTS

MESSAGE FROM DEPUTY SECRETARY BROADNAX

Reinforces the Secretary's commitment to keep employees informed on REGO II developments.

OS/OASH MERGER

Merges the Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH). The PHS agencies become operating divisions reporting directly to the Secretary, and the Assistant Secretary for Health becomes a staff position providing leadership, expertise and key advice to the Secretary on health and science issues.

#### CONSOLIDATION OF SURVEYS AND DEVELOPMENT OF DATA STANDARDS

Consolidates and redesigns HHS surveys and coordinates health and human service data standards across HHS. The Option Team formed a Department-wide Information System Committee which is working to identify the policy decisions needed.

#### GOVERNING COUNCIL ON CHILDREN AND YOUTH

Establishes a Governing Council on Children and Youth at the Secretary's level. The Option Team met in late May to begin sharing ideas and experiences about collaboration and improving the provision of coordinated, comprehensive services to children, youth and families.

#### AMERICAN INDIANS/ALASKAN NATIVES

The basic intent of REGO II with respect to American Indians and Alaska Natives is to improve the quality of services provided to people and communities through better coordination at the federal level.

#### CONSOLIDATION AND INTEGRATION OF AGING SERVICES

Examines how to provide seamless, customer-friendly services to the elderly through improved coordination and integrated, consolidated programs on the federal level.

#### FEDERAL EMPLOYEES OCCUPATIONAL HEALTH PROGRAM (FOH)

The FOH program is included in HHS's proposed pilot franchise program. If approved, this will mean that for the next three years FOH will remain a federal program, but will expand its customer base and will adopt some different ways of doing business - more comparable to the private sector.

#### AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR) CLINICAL PRACTICE GUIDELINES PROGRAM

AHCPR is planning to streamline the development of clinical practice guidelines and increase private sector contribution to this activity.

#### AHCPR TECHNOLOGY ASSESSMENT

AHCPR is proceeding with plans to phase out its intramural technology assessment program in favor of cooperative agreements with private sector assessment organizations.

#### OPERATION RESTORE TRUST

This intensive collaborative effort to attack Medicare fraud and abuse is now underway in the five target states--New York, Florida, Illinois, Texas and California.

Reinventing HHS, OS/OASH Merger -- REGO II (05/27/95)

OS/OASH News  
Issue #1

--An Update on the Progress of Planning the Reinvention of OS and OASH--

This is the first in a continuing series of newsletters updating employees on the progress of merging OS and OASH, one of the elements of HHS's Reinventing Government II (REGO II) initiative.

REGO II AND THE MERGER OF OS AND OASH

As the Vice President and Secretary Shalala announced on May 11, REGO II calls for merging the Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH). Specifically, the goal is to eliminate an entire organizational layer of management by consolidating two major policy, leadership and coordinating offices of the Department: OS and OASH. At the same time, many administrative services will be transferred to operating agencies, centralized in an internal business unit that offers competitive services, or contracted to the private sector or another Federal agency.

The health and science policy expertise of OASH will be incorporated into a redesigned Office of the Secretary, strengthening the capacity of the OS to provide executive leadership for the Department's health programs.

The Deputy Secretary is heading the Department's REGO II initiative, and chairs the Policy Steering Committee, which consists of OS, OPDIV and STAFFDIV heads, and union representatives. The Steering Committee will make final implementation recommendations to the Secretary. Reporting to the Policy Steering Committee is the Policy Support Group, led by LaVarne Burton (OS) and Jo Ivey Boufford (OASH), which will coordinate and support the Options Teams. Employee unions affected by the OS/OASH merger will be involved at various levels, including the Policy Steering Committee and the Options Teams.

THE OS/OASH TEAM

The Assistant Secretary for Health, Philip R. Lee, and the Assistant Secretary for Planning and Evaluation, David T. Ellwood, have been charged with leading the OS/OASH Team and are tasked with developing the implementation plan for merging OS and OASH. They have already designated several subcommittees which will be described in the next issue of OS/OASH News.

The OS/OASH Team is comprised of representatives from OS, OASH, OPDIVs, PHS Agencies, and unions. While much of the groundwork will occur in the Team's subcommittees, the Team will be responsible to the Deputy Secretary and the Secretary for the successful completion of an implementation plan for the option. Following are the OS/OASH Team representatives--

OPTION 4 (OS/OASH MERGER TEAM)

STAFFDIVs

- ASPE: David Ellwood (Co-Leader)
- Naomi Goldstein (Co-Coordinator)
- ASL: Rich Tarplin
- ASMB: Dennis Williams
- ASPA: Allan Rivlin
- ASPEH: Tom King
- ES: Jackie White
- IGA: John Monahan
- OCR: Omar Guerrero

OGC: Beverly Dennis  
OIG: Debra Robinson

OPDIVS  
ACF: Terry Herron  
AOA: Jack McCarthy  
HCFA: Bill Broglie

OASH:  
OASH: Phil Lee (Co-Leader)  
Susanne Stoiber (Co-Coordinator)  
MB: Tony Itteilag  
Tom Morford  
ES: Bob Rickard  
OSG: Dr. Audrey Manley  
OIA: Jarret Clinton

PHS AGENCIES

AHCPR: Dr. Lisa Simpson  
CDC: Jack Jackson  
FDA: Mary Pendergast  
HRSA: Jim Purvis  
IHS: Luane Reyes  
NIH: Dr. Ruth Kirschstein  
SAMHSA: Richard Kopanda

UNIONS

NTEU: Helen Duran  
AFGE: Peter Winch  
NFFE: To be named

TIMETABLE

Subcommittees are currently working to describe major functions and current organizational structures in OS and OASH, and present recommendations to David Ellwood and Phil Lee in late May. The Team will spend the month of June working out the overall plan, and in early July 1995, Ellwood and Lee will present recommendations to the Deputy Secretary.

IMPACT ON EMPLOYEES

The new HHS headquarters will be a leaner operation. It will be smaller than it is now in part because some functions will be transferred to OPDIVS or contracted out. In addition, eliminating redundancy will make reductions of approximately 400 positions possible by FY 2000. Combined with streamlining and other savings in the budget targets, these changes will result in a significant reduction in the size of the merged headquarters compared with 1993.

The Secretary stated in her remarks to employees on May 11, "I believe we can accomplish these changes without separating employees through RIPS -- or Reductions in Force." While employees may be assigned to new offices and different jobs, every effort will be made to avoid actions with adverse impacts on employees. OS and OASH will work together to develop a process for the transition of people and positions to the new structure, in partnership with the unions.

QUESTIONS OR COMMENTS?

If you have comments or have questions you would like answered in this newsletter, please send by internet to Burke Fishburn as follows: burkef@osaspe.ssw.dhhs.gov or you may telephone him at (202) 690-7807.

OS/OASH News is published by the Office of the Assistant Secretary for Planning and Evaluation in conjunction with the Office of the Assistant Secretary for Health.



PJ-5

4/10/94

DEC 29 1994

W J

The Honorable Robert Packwood  
United States Senate  
Washington, DC 20510

Dear Senator Packwood:

On behalf of the Department of Health and Human Services (HHS) and the Social Security Administration (SSA), we are pleased to provide you the enclosed plan to establish SSA as an independent agency on March 31, 1995, pursuant to section 105(c) of the Social Security Independence and Program Improvements Act of 1994.

We have made good progress since our October 31, 1994 interim report. We have worked together cooperatively to ensure that SSA and HHS both remain strong and capable after SSA becomes an independent agency. The major tasks to implement an independent SSA have either been completed or are well in progress. In those few instances where final decisions on administrative arrangements have not been made, we will continue to keep the General Accounting Office informed on our progress.

We will work closely together after SSA becomes independent to continue to provide quality service to our customers.

Sincerely,

Donna E. Shalala  
Secretary

Shirley S. Chater  
Commissioner  
of Social Security

Enclosure

DEC 29 1994

U51-1

The Honorable Bill Archer  
House of Representatives  
Washington, DC 20515

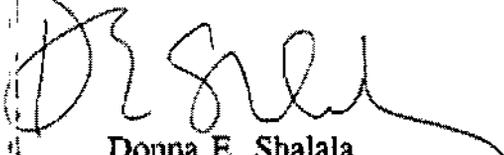
Dear Mr. Archer:

On behalf of the Department of Health and Human Services (HHS) and the Social Security Administration (SSA), we are pleased to provide you the enclosed plan to establish SSA as an independent agency on March 31, 1995, pursuant to section 105(c) of the Social Security Independence and Program Improvements Act of 1994.

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We will work closely together after SSA becomes independent to continue to provide quality service to our customers.

Sincerely,



Donna E. Shalala  
Secretary



Shirley S. Chater  
Commissioner  
of Social Security

Enclosure

: RF Comiller, SSA, ASPL



DEC 29 1994

PO-5  
US-1

The Honorable Sam Gibbons  
House of Representatives  
Washington, DC 20515

Dear Mr. Gibbons:

On behalf of the Department of Health and Human Services (HHS) and the Social Security Administration (SSA), we are pleased to provide you the enclosed plan to establish SSA as an independent agency on March 31, 1995, pursuant to section 105(c) of the Social Security Independence and Program Improvements Act of 1994.

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We will work closely together after SSA becomes independent to continue to provide quality service to our customers.

Sincerely,

Donna E. Shalala  
Secretary

Shirley S. Chater  
Commissioner  
of Social Security

Enclosure

C: RE (1-1/11/95) SSA, ASP, L



10-2  
US/1

DEC 29 1994

The Honorable Jim Bunning  
House of Representatives  
Washington, DC 20515

Dear Mr. Bunning:

On behalf of the Department of Health and Human Services (HHS) and the Social Security Administration (SSA), we are pleased to provide you the enclosed plan to establish SSA as an independent agency on March 31, 1995, pursuant to section 105(c) of the Social Security Independence and Program Improvements Act of 1994.

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Sincerely,

Donna E. Shalala  
Secretary

Shirley S. Chater  
Commissioner  
of Social Security

Enclosure

cc: R.F. Lynn - SSA ASPL



DEC 29 1994

P0-5  
USI-1

The Honorable Andrew Jacobs  
House of Representatives  
Washington, DC 20515

Dear Mr. Jacobs:

On behalf of the Department of Health and Human Services (HHS) and the Social Security Administration (SSA), we are pleased to provide you the enclosed plan to establish SSA as an independent agency on March 31, 1995, pursuant to section 105(c) of the Social Security Independence and Program Improvements Act of 1994.

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Sincerely,

Donna E. Shalala  
Secretary

Shirley S. Chater  
Commissioner  
of Social Security

Enclosure

cc: RE, (301/611) SSA, ASP, L



DEC 29 1994

The Honorable Daniel Patrick Moynihan  
United States Senate  
Washington, DC 20510

Dear Senator Moynihan:

On behalf of the Department of Health and Human Services (HHS) and the Social Security Administration (SSA), we are pleased to provide you the enclosed plan to establish SSA as an independent agency on March 31, 1995, pursuant to section 105(c) of the Social Security Independence and Program Improvements Act of 1994.

We have made good progress since our October 31, 1994 interim report. We have worked together cooperatively to ensure that SSA and HHS both remain strong and capable after SSA becomes an independent agency. The major tasks to implement an independent SSA have either been completed or are well in progress. In those few instances where final decisions on administrative arrangements have not been made, we will continue to keep the General Accounting Office informed on our progress.

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Sincerely,

Donna E. Shalala  
Secretary

Shirley S. Chater  
Commissioner  
of Social Security

Enclosure

*C&RF, Social Security, SSA, ASP, L*

**TRANSITION TO AN INDEPENDENT  
SOCIAL SECURITY ADMINISTRATION**

**INTERAGENCY TRANSFER AGREEMENT**

**Prepared By:  
The Department of Health and Human Services  
and  
The Social Security Administration  
January 1995**



TO: The Secretary

THRU: DS  
CoS  
ES

Dec 21 1994

*The 12/28/94  
Closely 12/28/94.*

FROM: Assistant Secretary for  
Planning and Evaluation

SUBJECT: Report to the Congress on Inter-Agency Transfer Arrangement: Act by  
December 31, 1994.

PURPOSE: To obtain your approval of and signature on a report to Congress on the joint  
HHS-SSA transfer arrangement with regard to SSA independence.

BACKGROUND: The "Social Security Independence and Program Improvements Act of  
1994" making SSA an independent agency requires you and the Commissioner enter into a  
written inter-agency transfer arrangement. That arrangement must specify the resources and  
personnel to be transferred. The Act requires the transfer arrangement to be transmitted not  
later than January 1, 1995, to House Ways and Means, Senate Finance, and GAO. The  
Appropriations Committees also have requested that they receive copies of the arrangement.

#### DISCUSSION

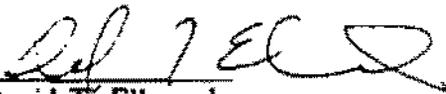
The plan has been developed with considerable discussion between SSA and OS staff, and  
involved the affected employees unions in the process. In particular, the Policy Group  
meeting with union presidents, chaired by Walter, was instrumental in determining and  
agreeing upon the procedures for selecting employees for transfer to SSA--one of the major  
tasks in the transfer arrangement. In sum, the report describes the terms and conditions of  
the arrangement for the transfer of personnel and resources to SSA, and notes that we have  
made good progress in preparing SSA for the assumption of its new duties and function.

We have provided a copy of the report in draft to OMB for comment.

#### RECOMMENDATION

I recommend that you sign the letters transmitting the report.

Attachments

  
David T. Ellwood

**TRANSITION TO AN INDEPENDENT  
SOCIAL SECURITY ADMINISTRATION**

**INTERAGENCY TRANSFER AGREEMENT**

**Prepared By:  
The Department of Health and Human Services  
and  
The Social Security Administration  
January 1995**

## Introduction

On August 15, President Clinton signed into law P.L. 103-296, the "Social Security Independence and Program Improvements Act of 1994", hereafter called the "SSA Independence Act". It establishes the Social Security Administration (SSA) as an independent agency, responsible for the administration of the Old-Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs. Under the legislation, SSA is also required to continue to perform its current functions in assisting in the administration of the Medicare and Medicaid programs, the Black Lung program, and the Coal Industry Retirees Health Benefits Act. SSA will be separated from the Department of Health and Human Services (HHS) on March 31, 1995.

This document is the joint HHS-SSA transfer arrangement required by Section 105(c) of the law. It describes the terms and conditions of the arrangement for the transfer of personnel and resources to SSA.

Shortly after the independent agency legislation was signed into law, Secretary Shalala and Commissioner Chater agreed upon a set of principles to guide the transition process. These principles reflect the commitment of HHS and SSA to work closely together during and after the transition period to ensure continuity of service to customers and fairness to employees. The specific transition principles are:

- Achieve the requirements of the legislation.
- Maintain continuity of work and quality customer service during and after transition.
- Maintain continuing two-way communication with employees and their unions providing as much information as quickly as possible.
- Fairly consider the needs of employees and seek to minimize adverse impact.
- Ensure a strong, effective and diverse workforce for HHS and an independent SSA.
- Balance functions and resources to retain the right mix of skills and knowledge and avoid future reductions in force.
- Involve all appropriate groups in the transition.
- Establish clear and open lines of communication between HHS and SSA and external organizations.

In keeping with these guidelines, HHS and SSA are utilizing a formal process for managing and coordinating transition activities. This process includes a policy and planning structure, supporting work groups and a tracking system to monitor specific transition activities. Employee union representatives are on a number of work groups and the national presidents of the two unions representing HHS and SSA employees are members of the Policy Group.

We have made good progress in preparing SSA for the assumption of its new duties and functions on March 31, 1995. The major tasks in the transition have either been completed or are well underway. We expect the transition to be very smooth.

## I. Functions to be Transferred

All major functions that HHS now performs for SSA will be transferred to SSA prior to it becoming independent. However, some administrative services will continue to be performed by HHS for a limited time after SSA becomes independent.

As an independent agency, SSA will assume responsibility for a number of new functions (e.g., general counsel advice, inspector general audits, and legislative drafting). Other functions (e.g., policy analysis) are being performed now by both SSA and HHS. Almost all functions will continue to be performed by both HHS and SSA after SSA becomes independent.

### a. Functions to be Transferred to SSA

#### EXECUTIVE DIRECTION AND MANAGEMENT

- Congressional and other liaison
- Research and evaluation
- Budget formulation and execution
- Personnel policy
- Grants and contracts policy
- Financial policy
- Civil rights
- Executive management and administration

#### LEGAL SUPPORT

- Litigation
- Legal advice and legislation
- Drafting and review of Federal Register items

#### INDEPENDENT INSPECTIONS AND REVIEW

- Audits
- Investigations
- Inspections and evaluations

#### PERSONNEL SERVICES

- Regional personnel services
- Headquarters personnel services
- EEO complaints/processing

- Payroll operations
- Personnel administration

#### ADMINISTRATIVE SERVICES

- Regional administrative services
- Regional financial services
- Accounting services
- Real property management
- Information resources support
- Material management
- Financial systems administration

A total of 1,143 FTEs will be transferred to SSA to perform these functions. A detailed breakout of the FTEs can be found in Section IV.a.

#### **b. How the Functions to be Transferred to SSA were Identified**

In July 1994, with legislation pending which would create an independent SSA, SSA and HHS initiated discussions regarding the steps which would need to be taken to transfer responsibilities and related resources from the Department to the new independent agency. Pursuant to these discussions, and shortly after the legislation was enacted, HHS planning staff conducted a survey of the staff divisions of the Office of the Secretary (OS) to help identify the Departmental functions which would need to be assumed in whole or in part by SSA.

The purpose of the HHS survey was to: 1) develop a benchmark of SSA-related Departmental functions and workloads, and 2) obtain benchmarks of the resources employed in each division that performs functions in support of SSA. The information collected, along with the identification of funds provided by SSA to HHS for services under the Working Capital Fund, and other funds HHS utilizes from Social Security Trust Funds, was used to help determine FTE and resource transfers.

## **II. Functions That Will be Retained After Independence**

#### **a. Functions that HHS will Perform for SSA**

HHS will continue to provide SSA with certain administrative services on an interim basis. These services include:

- The Payment Management System—which disburses and manages cash transfers to States for disability determination services and recipients of SSA research and demonstration project grants;

- The Federal Assistance Reporting System—which provides geographic distributions of obligations incurred for all programs;
- The Accounting for Pay System—which provides SSA payroll accounting data from the HHS central payroll system; and
- Payroll/personnel operations administration—to provide SSA with continued payroll services and automated system support (associated with payroll and personnel processing) for an interim period of two years.

**b. Functions that SSA will Perform for HHS**

**MEDICARE AND MEDICAID**

HHS and SSA will continue the longstanding collaborative and cooperative association that exists between SSA and the Health Care Financing Administration (HCFA). The Social Security and Medicare programs are highly integrated in order to achieve maximum administrative efficiency. Many basic workload functions in SSA also serve Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust fund activities and some are necessary for HHS operations. These activities include:

- shared claims-taking and adjudication costs for developing information on age, proof of identity and the determination of disability necessary for establishing entitlement to Medicare benefits;
- maintenance of earnings records (including processing annual reports of earnings, resolving earnings discrepancies, issuing employer identification numbers, and issuing earnings statements) that are used to determine eligibility for OASDI and HI and SMI for the disabled; and
- maintenance of the beneficiary rolls which, among other things, removes deceased persons from eligibility status.

In addition, SSA will process other workloads for HHS including:

- processing Medicare applications and disability determinations for retired Federal employees,
- collecting Medicare premiums, and
- responding to beneficiary inquiries on Medicare issues.

SSA will continue agreements with HCFA and the States to provide services on a reimbursable basis. Several cover the Medicaid program, such as the work done on Medicaid eligibility determinations and the information collected for mandatory assignment of rights, third party liability, the transfer of resources and Medicaid qualifying trusts. Other agreements cover expanded programmatic work done for the Medicare program, such as the Medicare Secondary Payer Match program activities conducted by SSA.

HHS and SSA will continue to exchange data necessary for program administration, as specified in Section 104(e) of the Act. HHS and SSA will

enter into an agreement under which the SSA will provide data concerning the quality of services to beneficiaries of, and administrative services in support of, the Medicare and Medicaid programs.

Reimbursable agreements will continue for certain administrative and support services provided to HHS for the shipment of Medicare tapes via express mail, and the keying of medical insurance application data.

Because of their commonality of interests, SSA and HCFA have established a joint interagency work group to monitor the impact of transition activities.

#### PARENT LOCATOR SERVICE

SSA will continue the work it does for the Administration for Children and Families concerning the Parent Locator Service.

#### REGIONAL PERSONNEL SERVICES

SSA will provide regional personnel services for an interim period of up to 1 year. During that period, permanent arrangements will be made.

### c. **How the Functions will be Reimbursed**

#### FUNCTIONS THAT SSA WILL PERFORM FOR HHS

SSA will continue to request funds through its consolidated administrative expense appropriation--the Limitation on Administrative Expenses (LAE) Account--to fund the cost of the Medicare work it does on behalf of HHS. The financial mechanism established in Section 201 (g) (1) of the Social Security Act authorizes the Commissioner to draw funds directly from the Medicare trust funds to pay the Medicare share of SSA's administrative expenses.

In addition, SSA and HHS will continue to enter into reimbursable agreements to ensure reimbursement for services performed by SSA in support of HHS general fund programs, such as Medicaid and Child Support Enforcement. Such agreements, authorized by the Economy Act, will provide for reimbursement and will spell out the terms and conditions of services provided.

The respective agencies will continue their longstanding cooperative relationship and exchanges of information and data which will enhance the delivery of services under their respective programs. The agencies will reimburse each other directly, through reimbursable agreements, memoranda of understanding and the financial mechanism established in Section 201(g) (1) of the Social Security Act.

HHS and SSA will jointly examine, by August 15, 1997, the most appropriate cost allocation methodology to be used to determine the costs to be borne by the Medicare trust funds for Medicare-related functions performed by SSA, as requested in the Conference Report on the Act. Existing financing arrangements will continue in force.

### III. Resources and Other Items to be Transferred

#### a. Accounts and Funds to be Transferred

The unobligated portion of that part of the three HHS appropriations providing for the functions/FTEs to be transferred to SSA also will be transferred and merged with SSA's LAE appropriation. The unobligated portion of the HHS appropriation for the BL program will be merged with SSA's BL appropriation. The three appropriations are:

**75-0120**

General Departmental Management, Departmental Management (FY)

**75-0128**

Office of Inspector General, Departmental Management (FY)

**75-0135**

Office for Civil Rights, Departmental Management (FY)

SSA and HHS have agreed that unobligated balances of HHS appropriations transferred to SSA will be merged into existing SSA accounts as appropriate. This approach will streamline accounting and fund control of the transferred funds and provide for funding the salaries and expenses of personnel transferred into SSA from the existing appropriations that are intended to fund such administrative expenses. We are reviewing whether any changes to the account structure may be needed.

#### b. Budget

Pursuant to the SSA Independence Act, the appropriate portions of the FY 1995 appropriations will be transferred to the new independent SSA effective April 1, 1995. Since the FY 1996 President's budget will not reflect final transfer decisions, a budget amendment may be necessary.

#### c. Records and Other Property to be Transferred

##### PERSONNEL AND FINANCIAL RECORDS

HHS will transfer to SSA all appropriate records related to people and resources to be transferred.

##### OFFICE OF THE GENERAL COUNSEL (OGC) AND OFFICE OF THE INSPECTOR GENERAL (OIG) RECORDS

All of the records which relate to SSA business maintained by the OGC and OIG staffs will be transferred.

**PERSONAL PROPERTY**

Equipment, such as desks and computers, now used by employees transferred to SSA will be transferred with them. An onsite survey will be conducted by SSA and HHS in each area where employees have been identified for transfer to identify all furnishings and equipment (including Automated Data Processing equipment) that will be accompanying the affected employee. If furniture and computer equipment are being shared, the amount of time the items are used by the employee identified for transfer will determine ownership. Items identified during the survey as accountable will be given an SSA barcode and entered into SSA's Centralized Property Accountability System.

**d. Regulations, Contracts and Grants, Lawsuits, et al.****REGULATIONS**

Per Section 106(b) of the SSA Independence Act, HHS regulations which affect SSA, as they exist on March 30, will continue in effect until they are modified, terminated, repealed, or set aside by the Commissioner of Social Security. HHS issues regulations that pertain to all of the HHS operating and staff divisions, making it unnecessary for the HHS components to issue duplicative rules. As an independent agency, SSA will issue rules on some subjects which were included in overall HHS rules. SSA plans to issue a rule on or before March 31, identifying the proper SSA official(s) on whom process should be served.

SSA is developing schedules for the publication of Departmental regulations that need to be reissued as SSA regulations. The Office of the Federal Register has provided electronic copies of relevant portions of the Code of Federal Regulations, which will be used to migrate the rules most effectively.

**AGREEMENTS AND GRANTS**

Just as regulations will remain in effect, so also will contracts. On behalf of HHS, SSA has entered into several agreements with a number of States and the District of Columbia to make, for example, their Medicaid eligibility determinations. In addition, there are agreements involving Interim Assistance Reimbursement, State Supplementary Payments and agreements through HCFA covering related Medicaid eligibility determination factors such as Assignment of Rights, Third Party Liability and Transfer of Resources. At the present time, all of the agreements are under review to determine if modifications to the current responsibilities should be made. This review may result in the preparation of several MOUs or Interagency Agreements between the newly independent agency, the States and HCFA.

SSA also has entered into agreement with the Departmental Appeals Board (DAB) to confer on DAB the authority to review certain disputes arising between SSA and the various states during the performance of the obligations set out in the agreements. SSA has initiated action to determine the extent to

which it uses the DAB and examine options as to how SSA will resolve disputes of this nature as an independent agency. This activity may also result in a contract, MOU or Interagency Agreement with DAB to continue the authority to review certain disputes.

**LAWSUITS**

Sections 106(c) (d) (e) and (f) of the SSA Independence Act provide that all proceedings, suits, penalties, and judicial reviews pending before the Secretary as of March 30, with respect to functions vested in the Commissioner of Social Security, shall continue before the Commissioner. As such, there will be no abatement of activity relative to these sections, and judgments will continue to be rendered.

**IV. Personnel To Be Transferred**

**a. Number of FTEs to be Transferred by Function**

HHS will transfer to SSA a baseline total of 1,143 FTEs. The actual number of FTEs transferred may differ slightly from the baseline figure, depending on the impact of temporary cross-servicing arrangements, buyouts, and other departures of employees.

As requested in the Conference Agreement on the SSA Independence Act, we have broken out the baseline FTE total by OS Division. These figures are as follows:

<u>OS Division</u>	<u>Baseline FTEs</u>
Immediate Office	5
Legislation	1
Planning and Evaluation	6
Management and Budget	99
Personnel Administration	478
General Counsel	289
Inspector General	263
Civil Rights	2
<b>TOTAL</b>	<b>1,143</b>

The number of FTEs to be transferred is based on:

- consideration of the principles guiding the transition;
- a comprehensive survey undertaken by OS to identify a baseline of departmental functions, workloads and resources in each office which perform functions in support of or related to SSA, and subsequent

discussion between SSA and OS staff;

- consideration of funding OS receives related to programs that SSA administers, particularly Social Security trust funds and SSA payments into the Working Capital Fund; and
- judgments with regard to SSA's and HHS's respective needs and OS offices' particular circumstances.

The adjustment to the baseline FTE number for buyouts in OS will be made in proportion to the amount of time spent on SSA matters. For example, 85 percent of the HHS regional personnel office work is SSA-related, while 15 percent is related to other HHS components. As such, reductions due to buyouts of staff performing this function would be allocated 85 percent to SSA and 15 percent to HHS.

**b. Matching Personnel to FTEs and When this will Occur**

The process for identifying employees to be transferred to SSA incorporates some of the current transfer of function rules with flexibilities provided by the law. SSA and HHS will balance the transfer of functions and resources so that each agency retains the right mix of skills while fairly considering the needs of the employees selected for transfer.

The selection process is as follows:

**PROCESS**

Transfer of function rules will be used as a baseline with final determinations made using various added flexibilities. The process will have the following basic steps, using as many as necessary to fill the FTEs allocated for transfer from the HHS Staff Division (STAFFDIV). SSA and STAFFDIV representatives will work through the process together, basing decisions on the mix of skills that will best contribute to organizational viability on both sides while considering special needs of employees.

- Employees performing SSA work 100% of the time/dedicated employees will be transferred.
- Employees spending 50% or more (but less than 100%) of their time on SSA work will be identified for transfer, but can be retained in HHS by mutual agreement between HHS and SSA to cover special situations (e.g., continued viability of small offices, skills mix, or hardship accommodation).
- Volunteers will be solicited to fill remaining FTEs agreed to for transfer. To the maximum extent possible, consistent with organizational needs and interest, volunteers will be used to fill the remaining slots before any involuntary transfers are proposed.

SSA will determine and describe the types of positions it needs to carry out the transferred functions with a level of specificity to fit the particular situation. Employees will be given this information before they are asked

formally to volunteer.

- Volunteers spending some of their time (but less than 50%) on SSA work will be given first consideration for selection. Selections will be mutually agreed to by SSA and HHS, the primary goal being to attain a skills mix that will contribute to organizational viability on both sides. In making determinations, consideration will be given to the amount of time a volunteer spends on SSA work and the volunteer's service computation date.
- If the number of selections from among volunteers in the SSA-related category is insufficient to meet FTE requirements, volunteers who spend no time on SSA function but who have the needed skills will be considered. Again, selections will be mutually agreed to by SSA and HHS.
- If slots required to be transferred to SSA still remain unfilled after using the three preceding steps, employees spending some time on SSA work, but less than 50%, will generally be selected for transfer based on inverse service computation date and the needed grades and series, but can be retained in HHS by mutual agreement between HHS and SSA to cover special situations (e.g., continued viability of small offices, skills mix, hardship accommodation).
- Employees identified for transfer, or denied a request to transfer, can request reconsideration of those decisions. Reasons for requesting reconsideration include, but are not limited to (a) instances where the available documentation does not support their identification (i.e., amount of time spent on SSA work) or, (b) transferring would pose a hardship. A panel composed of HHS, SSA, and union representatives will review each reconsideration request on its merits. If the panel reaches consensus among its members to approve the request, that is the final action. In cases where the panel cannot reach consensus, the recommendations of its various members will be forwarded to the Secretary and the Commissioner, or their designees, who will make the final decision.

#### PROPOSED TIMELINE

- January 10: Preliminary transfer notices issued to 100%/dedicated employees and employees who spend 50-99% of their time on SSA work
- Volunteers formally solicited
- January 17: Reconsideration requests and volunteer responses due

- January 31: Reconsideration decisions issued
- Final notice issued to 100%/dedicated employees and 50-99% employees
- Volunteers notified of selection
- Preliminary transfer notices issued to (nonvolunteer) employees who spend some time (but less than 50%) on SSA work
- February 7: Reconsideration requests from less-than-50% group due
- February 21: Reconsideration decisions issued
- Final notices issued to less-than-50% group

## V. New Accounts, Systems, Relationships and Organizations to be Established

### a. Accounts and Other Direct Relationships to be Established with GSA, Treasury, etc.

#### RECORDS MANAGEMENT AND PRINTING

HHS and SSA will make formal notifications for SSA to deal directly with other Federal agencies concerning printing. SSA will then deal directly with the National Archives and Records Administration on all records management issues. SSA staff also will begin to deal directly with the Joint Committee on Printing.

#### CONTRACTS AND GRANTS

SSA's Office of Acquisition and Grants is in the process of establishing direct contact with a number of Federal agencies to carry out SSA's acquisition and grants management responsibilities, including the Federal Procurement Data Service, the Small Business Administration, GSA, GAO, the Office of Federal Procurement Policy and the civilian Agency Acquisition Council.

#### GSA DELEGATIONS OF AUTHORITY

SSA has notified GSA of the need to alter existing delegations effective March 31. At SSA's request, prior to March 31, GSA will issue all correspondence and directives to both Departmental and SSA officials, in headquarters and the regional offices. SSA has requested GSA to designate a national account executive for SSA as an independent agency.

#### OUTSIDE AUDIT AND OFFICES

Several years ago, SSA established direct liaison with GAO and other outside study groups, such as the Office of Technology Assessment. Therefore, no new action will be needed.

**DIRECT RELATIONSHIPS TO BE ESTABLISHED WITH TREASURY AND OTHER FINANCIAL OVERSIGHT ENTITIES**

SSA has initiated discussions to establish direct relationships with financial oversight entities. The key entities and subject areas covered include:

- Consistent with the provisions of Section 104(b) (1) of the SSA Independence Act, OMB in the area of budget, financial policy, procedures and systems including financial statement and Government Performance and Results Act requirements. SSA is discussing revised reporting dates and formats for its 5-Year Plan, Annual Financial Statement and Federal Manager's Financial Integrity Act reports consistent with provisions of the Government Management Reform Act of 1994. SSA also will work directly with OMB on budget formulation and execution.
- OMB in the area of regulations and information collection. SSA has already obtained information collection numbers from OMB.
- The Department of Treasury in such areas as central accounting, trust fund collections, payment issuance and claims processes management of the Federal Debt and trust fund reserves, cash and asset management reporting, etc.
- SSA and the Department of Treasury have agreed to realign all fund symbols and Agency Location Codes (ALCs) assigned to the new independent SSA. Since Treasury requires only a 30 day lead time, we anticipate no problems or delays in implementing the necessary changes.
- The Chief Financial Officers Council (CFO) where the SSA CFO will work with representatives of other large Federal agencies and senior officials at OMB and Treasury to improve financial management in the Federal government.
- GSA where SSA will begin to deal directly with GSA on space rental billing and payment, Federal Travel Policy and regulations and the Federal chargecard program.
- GAO in the area of Comptroller General opinions on the use of appropriated funds and claims against the Federal government.
- The Federal Reserve Board on electronic fund transfer, electronic data exchange and international direct deposit.
- The Federal Accounting Standard Advisory Board on a wide range of fiscal and accounting issues including asset, liability and inventory accounting and standards for Federal government cost accounting.
- Federal interagency steering committee that administers the Joint Financial Managers Improvement Program (JFMIP) where SSA is discussing a direct relationship and strong support of JFMIP objectives.

- The National Institute of Standards and Technology on systems security standards and the development of new technologies to address security issues.

**b. New or Modified Computer Systems**

In view of the cross-servicing agreements reached regarding payroll and personnel services, SSA will not require any additional systems capabilities at this time.

**c. Organizational Changes**

As an independent agency, SSA will establish new organizations to incorporate functions previously performed for SSA by HHS. SSA has explored a variety of options for organizing these new functions (e.g., General Counsel, Inspector General, regional personnel services) and establishing appropriate reporting relationships. SSA and HHS representatives have discussed options for organizing these new functions in both headquarters and the field and the impact they will have on SSA's existing functions and organizations. In addition, SSA and HHS established work groups to identify options for services that HHS will continue to provide for SSA, such as payroll, and for services that SSA will provide for HHS, such as regional personnel management support.

Regarding the regional structure that an independent SSA will require, SSA has considered a number of options that examine a variety of issues (e.g., the optimum organizational configuration for the field; which functions should report directly to headquarters and which to the Regional Commissioner; what is the role of the Regional Commissioner in an independent SSA). The range of options were discussed with the entire SSA executive staff. The Commissioner is now reviewing the options.

SSA will have an effective organizational structure in place to enable SSA to function as an independent agency on March 31. It will include revitalizing its policy development functions by, among other things, expanding its policy analysis capability and consolidating all program policy functions under one executive. Additional organizational changes will be considered after SSA is independent, consistent with SSA's experience and the intent of the legislation.

A variety of approaches will be used to incorporate the new SSA functions and employees that SSA will gain as a result of independence. Where the function is new to SSA, such as the IG and GC, new organizations will be established. In those situations where SSA will be adding HHS employees to an existing SSA organization, such as in the budget function, new positions will be established or allocations added to existing positions.

The HHS IG is working with SSA to assist in establishing the SSA Office of the Inspector General, in particular to ensure that it has a viable staff with the skills needed to accomplish their mission. In addition to determining

staffing needs, arrangements are being made to assure continuity of investigations, audits and evaluations underway as of March 31, 1995.

**d. Washington Space**

On SSA's behalf, GSA has advertised for some 64,000 square feet of office space to house SSA's Washington office. The space sought will accommodate approximately 175-200 people. It will provide offices for the Commissioner, Deputy Commissioner and other senior agency officials, a Washington-based staff for legislative and related activities, and the research and statistics staff already housed in another building in Washington. The site must, of course, meet all Americans with Disabilities Act (ADA) requirements.

Based on the delineated space needs, GSA is evaluating all expressions of interest it receives and is rejecting some as non-responsive (e.g., not suitable for first class office space, not capable of meeting ADA standards). SSA staff visited all potentially suitable sites with GSA to determine their viability.

**VI. Mechanisms to Implement the Transfers**

**a. Agreements to be Signed**

SSA and HHS will sign MOUs for arrangements or Interagency Agreements as previously discussed in Section II.

**b. How the Transfers will be Effectuated**

The principal transfer mechanism will be a determination order issued by OMB. SSA has initiated discussions with Treasury, OMB and HHS staff to lay the groundwork for preparation and processing of the order.

In addition, certain other documents--such as reapportionment of transferred resources, non-expenditure transfer authorization, and transferred personnel listings will be prepared.

**VII. Timetable for Activities Scheduled for Completion by March 31**

A complete set of activities with due dates is shared regularly with the staff of the General Accounting Office. Highlights of some of those activities follow:

<u>Due Date</u>	<u>Activity</u>
January 10	<ul style="list-style-type: none"> <li>■ Preliminary transfer notices issued to HHS employees identified for transfer.</li> <li>■ Solicitation of HHS employees who wish to volunteer for transfer to SSA.</li> </ul>

- January 31
  - Final notices issued to those employees identified for transfer.
  - Volunteers notified of selection.
  - Preliminary notices issued to other HHS employees.
- February 21
  - Final notices issued to remaining employees.
- March 20
  - Final determination of personal property facilities and/or space to be transferred or shared.
- March 31
  - Determination order issued by OMB.
  - All other MOUs, Interagency Agreements, reapportionments, authorizations and other listings become effective.